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## ABSTRACT

The purpose of the Individuals with Disabilities Education Act, IDEA, is to ensure that all children with disabilities have access to an appropriate public education. However, schools may be barring that access for many children with mental and emotional disorders by using inadequate assessment rules. Children who fail to qualify under the IDEA will not receive the services and supports that would enable them to benefit from their education. The resulting school failure makes it nearly impossible for these children to become independent and productive adults. The impending renewal of the IDEA could offer them new hope. The information in this issue brief illustrates the need for federal policy changes to encourage earlier and more accurate identification of children with mental and emotional disorders under the IDEA. It highlights research on the IDEA's definition of "emotional disturbance" and summarizes findings from a study by the Bazelon Center on the possible impact of that definition on identification rates. (GCP)

# *Failing to Qualify: The First Step to Failure in School?*

## A Bazelon Center Issue Brief

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## **Failing to Qualify: The First Step to Failure in School?**

### **CONTENTS**

The IDEA and Children with  
Mental or Emotional Disorders

IDEA Identification Rates

- •Children are underidentified.
- •Children are misidentified.
- •Identification is often delayed.
- •Ethnic and cultural factors influence children's identification.

Inappropriateness of the Federal  
Definition

An Alternative Definition

Comparison of Definitions

- •Social Maladjustment
- •Measures of Achievement
- •Cultural Factors
- •Normative Measures
- •Behavior in Different Settings
- •Eliminating Transient Problems
- •Children from Birth to Age Six
- •Duration
- •Pre-Referral Services
- •Diagnosis

The Alternative Definition and  
Identification Rates

States Making Changes to  
Definition Consistent with  
Recommendations in the  
Alternative Definition

Discussion

Recommendations for Action

Conclusion

Notes

Tables

- •States' identification rates and modifications to the federal definition of emotional disturbance
- •Number of children 6-21 served under part B, IDEA, compared with estimated number of children with mental disorders and functional impairments

### **INTRODUCTION**

The purpose of the Individuals with Disabilities Education Act, IDEA,<sup>1</sup> is to ensure that all children with disabilities have access to an appropriate public education. However, schools may be barring that access for many children with mental and emotional disorders by using inadequate assessment rules. Children who fail to qualify under the IDEA will not receive the services and supports that would enable them to benefit from their education. The resulting school failure makes it nearly impossible for these children to become independent and productive adults. The impending renewal of the IDEA could offer them new hope.

From the first days of the federal special education law now known as the IDEA, the definition of children who have "emotional disturbance" has been criticized as not grounded on the science of mental health assessment. IDEA identification of children with these disorders remains low—far below even the most conservative estimates of the prevalence of severe childhood mental disorders accompanied by extreme functional limitations. Further, new research shows that schools misidentify a significant number of these children and place them in other IDEA categories. Moreover, unlike children with other disabilities, these children's disorders are commonly not identified until adolescence, even though recent research suggests that young children's emotional and behavioral problems are identifiable early and amenable to reduction over time.<sup>2</sup>

There has therefore been considerable interest in ascertaining whether states' interpretations of the federal definition—and some states significantly alter the definition—affect the number of children identified as needing special education and related services that would lead to success in school.

The information in this issue brief illustrates the need for federal policy changes to encourage earlier and more accurate identification of children with mental and emotional disorders under the IDEA. It highlights research on the IDEA's definition of "emotional disturbance" and summarizes findings from a study by the Bazelon Center on the possible impact of that definition on identification rates.

States can also act to improve identification of children with mental and emotional disorders under the IDEA. They have the flexibility to interpret the federal definition and some have done so to positive effect. The Bazelon Center

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The Bazelon Center is the leading national legal advocate for adults and children with mental disabilities. Its mission is to protect these individuals' rights to exercise meaningful life choices and to enjoy the social, recreational, educational, economic, political and cultural benefits of community life.

The staff uses a coordinated approach of litigation, policy analysis, coalition-building, public information and technical support for local advocates to end the segregation of children and adults with mental disabilities and assure them of the opportunity to access needed services and supports.

BAZELON CENTER FOR  
MENTAL HEALTH LAW  
1101 15<sup>th</sup> Street NW, # 1212  
Washington DC 20005  
(202) 467-5730

study examines the relationship between states' identification rates and their specific modifications to the federal definition. While considering changes in definitional criteria applied in eligibility determinations, states should also address whether children with mental and emotional disorders are being identified in numbers consistent with prevalence rates so that special education and related services they need can be furnished under the IDEA.

### **THE IDEA AND CHILDREN WITH MENTAL OR EMOTIONAL DISORDERS**

Currently, schools often take a punitive, exclusionary approach to the problems exhibited by children with mental and emotional disorders. Zero tolerance is now common for certain behaviors. Such "get tough" policies encourage the exclusion from school of disruptive children, particularly adolescents. Instead of offering special education and related services early, many schools now pass their responsibilities on to the larger society, leaving children in need of help to flounder.

Federal law calls for a better approach to assisting youngsters who are found to have emotional disturbance and who have been referred for special education. The 1997 IDEA amendments renewed the emphasis on addressing behavioral problems proactively and effectively. The law requires inclusion in the child's Individualized Education Plan (IEP) of positive behavioral interventions, which are more appropriate and effective for troubled students than punitive approaches.

While education policy focuses heavily on academic achievement, this should not lead schools to overlook early signs of problems, such as a young child's failure to establish relationships with teachers and peers, that often foretells later school failure.<sup>3</sup> Children at the greatest risk for later behavior problems can be identified through effective screening in the early grades,<sup>4</sup> and effective interventions exist. But without such interventions, risk factors have a cumulative effect.<sup>5</sup> The inevitable result is greater expense and more serious problems for communities down the line.

Correct identification is also critical, to ensure that each child receives appropriate, effective services. Children who have academic difficulties stemming from a mental or emotional disorder will likely not improve their educational performance without mental health services; a program designed for learning-disabled students will probably not be nearly as helpful.

Children with mental disorders are even less likely to succeed if subjected to suspension or expulsion. A recent study found that 73 percent of youth identified with serious emotional disorders who have dropped out of school are arrested within five years. A major national study in 1991 found 35 percent of

such students were arrested within two years after leaving school.<sup>6</sup> In fact, the prevalence of youth with emotional disabilities is estimated to be at least three to five times greater in juvenile correctional facilities than in public schools.<sup>7</sup> School policies that lead children to drop out are not in the best interest of either the child or the wider community.

Schools are increasingly being encouraged to collaborate with local mental health systems to develop services both for students in special education and for students with mental health problems not severe enough to qualify them for such designation.<sup>8</sup> The President's Commission on Excellence in Special Education urges that states have the flexibility to combine IDEA funds with those of other agencies.<sup>9</sup> Recently, state directors of special education and mental health joined together to issue a concept paper on the importance of such collaborations, with concrete suggestions on how this can be done.<sup>10</sup>

Collaborative efforts will lessen the burden on the schools and promote school-wide policies that both reduce the effects of mental or emotional disorders in students eligible for IDEA and prevent behavioral problems.<sup>11</sup> Schools then should either offer pre-referral mental health services and supports or place children appropriately in special education.

#### **IDEA IDENTIFICATION RATES**

##### **Children are underidentified.**

Students with mental and emotional disorders (termed "emotionally disturbed" under the IDEA<sup>12</sup>) have been cited as among the most under-identified and underserved students with disabilities.<sup>13</sup> For more than two decades, the national rate of students identified with emotional disturbance hovered just under 1 percent;<sup>14</sup> by 2001 it had fallen to 0.74 percent. In stark contrast, the U.S. Surgeon General estimated that nationwide 5 percent of all school-age children have mental disorders with "extreme functional impairment" and 11 percent have mental disorders with "significant functional impairment."<sup>15</sup> The box at left presents data on this gap, comparing the percentage of children identified as emotionally disturbed in schools with children estimated to have mental disorders accompanied by extreme or significant functional impairment. State-by-state data are presented in Table 1.

The low overall rate of identification under the IDEA hides the fact that some states identify almost no children as having mental or emotional disorders. Rates of identification have consistently varied considerably by state.<sup>16</sup> State identification rates are also shown in Table 2.

Since 1991, children with attention deficit/hyperactivity disorder (ADD/ADHD), have been eligible for inclusion within the "other health impaired" category of the IDEA. Since then there has been a 350-percent

#### **COMPARISON OF IDENTIFICATION RATES**

National IDEA identification of children with emotional disturbance	0.74%
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National IDEA identification of children with other health impairments	0.4 %
--	-------

U.S. Surgeon General's identification of children with mental disorder + extreme functional impairment	5 %
--	-----

U.S. Surgeon General's identification of children with mental disorder + significant functional impairment	11%
--	-----

#### **RANGE OF IDENTIFICATION RATES ACROSS STATES**

##### **IDEA category of Emotional Disturbance**

Highest state rate (Minnesota, Vermont)	1.92%
---	-------

Lowest states' rate (Arkansas)	0.10%
--------------------------------	-------

increase in the number of students in this category, attributed by the Department of Education largely but not exclusively to the inclusion of children with ADD/ADHD. However, the overall rate of identification for Other Health Impairments is low, and in some states it is zero.<sup>17</sup> Even if all the children who cause such an increased number in this category were those with ADD/ADHD, they would not raise the rate of identification for children with mental and emotional disorders significantly.<sup>18</sup>

Based on earlier and less well researched estimates that only 2 to 3 percent of school-age children had mental or emotional disorders serious enough to adversely affect their educational performance,<sup>19</sup> schools were criticized for failing to identify and assist even half the children with emotional disturbance who should have qualified under the IDEA.<sup>20</sup> Today the data suggest that states may be failing to correctly identify *four fifths* of qualified children.

A number of reasons have been put forward for this gap, including:

- The federal definition—due to its vague language, undefined terms and inappropriate criteria—allows significant under-identification of children with emotional disturbance.<sup>21</sup>
- Children with mental and emotional disorders, as a group, often exhibit behaviors that disrupt the classroom and make them unpopular; schools would rather remove them than offer them services.<sup>22</sup>
- Schools assume that the costs of providing services will be high and that if the child is not identified for special education and related services under the IDEA, the mental health system will nonetheless provide the necessary services and supports.<sup>23</sup>
- School officials are concerned about the impact of a “mental health” label for the child, due to the stigma of mental or emotional disorders.<sup>24</sup>

**Children are misidentified.**

The problem of under-identification is probably even worse than the above figures seem to indicate because large numbers of children are misidentified. Research now indicates that schools misidentify almost as many children with mental and emotional disorders as they identify accurately.<sup>25</sup> One study found that nearly half of a group of children with mental and emotional disorders were identified by schools as learning disabled, even though the study carefully excluded any children with co-occurring learning disabilities.<sup>26</sup> The authors of this study point out that this misidentification likely leads to provision of services and supports that are misdirected and less helpful than if the child were correctly identified.

Even including misidentified children within the group of children with emotional disturbance identified under the IDEA for special education does not raise the identification rate to a level consistent with the findings on the

increased number of school-age children with mental disorders. Doubling the identification rate as suggested by the above-mentioned study would only lead to identification of 1.5 percent of school-age children with mental disorders.

**Identification is often delayed.**

Even when schools correctly identify students as having mental or emotional disorders, the identification is typically delayed. Children in this category are identified at a mean age of 10, and many not until adolescence.<sup>27</sup> Effective prevention of school failure depends crucially on early recognition and provision of services for troubled children. Delayed identification results in children's requiring more intensive IDEA services once they are identified. For example, these children are disproportionately placed in the most restrictive settings and are far less often mainstreamed than children with other disabilities.<sup>28</sup> Early identification is not difficult. Although these children are not being identified by their schools, parents and professionals recognize mental and emotional disorders in children at a very young age—often well before the child even starts school.<sup>29</sup>

**Ethnic and cultural factors influence children's identification.**

Furthermore, there is considerable agreement that differential treatment of minority children has been a problem in special education since enactment of the federal law.<sup>30</sup> Regardless of the effects of social, demographic and school-related factors, gender and ethnicity are significantly associated with the risk of being identified for special education. This is particularly the case for the special education categories of mental retardation and emotional disturbance. African American and American Indian children, particularly boys, are over-represented in the category of emotional disturbance, while Asian/Pacific Islander and Hispanic children are under-represented.<sup>31</sup> A significant portion of this over- and under-representation appears to be a function of inappropriate interpretation of ethnic and cultural differences.<sup>32</sup>

**FEDERAL DEFINITION**

A condition exhibiting one or more of the following characteristics, displayed over a long period of time and to a marked degree that adversely affects a child's educational performance:

- (1) an inability to learn that cannot be explained by intellectual, sensory or health factors;
- (2) an inability to build or maintain satisfactory interpersonal relationships with peers or teachers;
- (3) a general pervasive mood of unhappiness or depression;
- (4) a tendency to develop physical symptoms or fears associated with personal or school problems.

This term includes schizophrenia, but does not include students who are socially maladjusted, unless they have an emotional disturbance.

**INAPPROPRIATENESS OF THE FEDERAL DEFINITION**

The federal definition of emotional disturbance is neither clear nor comprehensive enough to determine eligibility under IDEA appropriately.<sup>33</sup> It fails to distinguish between students with emotional disturbance and non-disabled peers and it is also at odds with prevailing wisdom in the field of special education and with accepted practice.<sup>34</sup> It is, in the words of one expert, illogical.<sup>35</sup> (See box for language in the federal definition.)

Many aspects of the federal definition have been criticized. Its main criteria (numbers 1-4 in the definition) are not supported by research on subtypes of children.<sup>36</sup> The reference to adverse educational performance is too narrow and is interpreted as addressing only academics and failing to take into account

**ALTERNATIVE DEFINITION  
FROM MENTAL HEALTH  
AND SPECIAL EDUCATION  
COALITION**

(i) The term emotional or behavioral disorder means a disability characterized by behavioral or emotional responses in school so different from appropriate age, cultural or ethnic norms that they adversely affect educational performance. Educational performance includes academic, social, vocational and personal skills. Such a disability:

(A) is more than a temporary expected response to stressful events in the environment;

(B) is consistently exhibited in two different settings, at least one of which is school-related; and

(C) is unresponsive to direct intervention in general education or the child's condition is such that general education interventions would be insufficient.

(ii) Emotional and behavioral disorders can co-exist with other disabilities.

(iii) This category may include children or youth with schizophrenic disorders, affective disorders, anxiety disorders or other sustained disturbances of conduct or adjustment when they adversely affect educational performance in accordance with section (i).

social and behavioral factors that influence academic achievement.<sup>37</sup> Its terminology is vague and terms are not explicitly defined.<sup>38</sup> It has also been criticized for focusing too much on the process of assessment, emphasizing procedures to see if the child fits into one of the arbitrary five categories.<sup>39</sup>

The section of the definition cited as most inappropriate is the exclusion of children on the basis of "social maladjustment"—a term that is not defined. It has been argued that these children intentionally break rules and are more appropriately referred to the juvenile justice system.<sup>40</sup> However, research finds no justification for a distinction between mental/emotional disorder and social maladjustment<sup>41</sup> and even if it did exist, no valid instruments exist to make such a distinction.<sup>42</sup> Furthermore, the reference to social maladjustment is inconsistent with other parts of the definition, as social maladjustment virtually defines the behavior of any child with significant mental/emotional disorders.<sup>43</sup> The federal definition now incorporates criteria regarding social relationships that would identify certain children as eligible, but at the same time excludes these children because they are "socially maladjusted."<sup>44</sup>

Students with mental and emotional disorders who are excluded from special education and related services because of the social maladjustment clause are at high risk for suspension or expulsion due to the behavioral manifestations of their disorder. Yet many suspended students who have not been found eligible for special education and students with mental and emotional disorders who are in special education are often indistinguishable from each other. In fact, the majority of students who have been identified as emotionally disturbed by their school have a conduct disorder and thus exhibit some of the behaviors for which others are suspended or expelled.<sup>45</sup> Sorting students into two groups—suspending one group and giving the other access to special education and related services—cannot be justified from the research.<sup>46</sup>

**AN ALTERNATIVE DEFINITION**

In 1989, 30 professional mental health and education associations collaborated to produce an alternative definition that states could substitute for the federal definition. This alternative was later adopted with minor modifications by the Council for Exceptional Children, representing special education teachers of children with emotional disturbance (see box).

The alternative definition allows the assessment to focus on the degree of difference in the child's behavior and to establish that a significant impairment exists.<sup>47</sup> It does not incorporate the distinction between emotional disturbance and social maladjustment. This definition is structured to be more in line than the current federal definition with other IDEA definitions, particularly those for learning disabilities and mental retardation. It requires the use of normative standards, including culture, which the federal definition ignores. It also requires consideration of the potential value of pre-referral services. While not a

panacea for the problem of under-identification, this alternative definition would be at least a partial solution.<sup>48</sup>

### **COMPARISON OF DEFINITIONS**

The federal definition and the alternative definition proposed by national mental health and special education organizations have the following important differences:

#### **Social Maladjustment**

Perhaps the most controversial aspect of the federal definition is the exclusion of children with "social maladjustment." "Social maladjustment" has been mistakenly equated in many states with the mental health diagnosis of conduct disorder.<sup>49</sup> The alternative definition deletes the reference to social maladjustment and thus eliminates the need to make a meaningless distinction.

#### **Measures of Achievement**

The federal definition focuses on academic performance while the alternative definition broadens the criteria used to measure the impact of the child's disorder on educational achievement. It emphasizes the child's adaptive skills that result in an ability to learn.

#### **Cultural Factors**

There is no reference in the federal definition to cultural factors that may influence a child's behavior. Cultural traits, behaviors and beliefs are likely to be interpreted as problems to be overcome. This can lead to misidentification and differential placement rates between children of different backgrounds.<sup>50</sup> The alternative definition encourages schools to incorporate an assessment of the impact of cultural norms on the child's behavior.

#### **Normative Measures**

There is no reference in the federal definition to whether the child's behavior differs substantially from the normal behavior expected of his or her peers, in terms of age and other developmental factors. The alternative definition includes age as well as cultural or ethnic norms.

#### **Behavior in Different Settings**

The federal definition fails to acknowledge that children behave differently in different situations, and may react differently in school than they do at home or in the community.<sup>51</sup> The alternative definition allows the child's behavior to be assessed in various school settings—classrooms, lunchroom, playground—and, if parents raise these issues, in home and community as well. The alternative definition also safeguards against identifying a child due to behavior that only manifests itself in a particular classroom.

**Eliminating Transient Problems**

The federal definition requires that certain characteristics be displayed by the child “to a marked degree,” but this term is not defined. The federal definition does not discriminate between problems caused by a significant and long-lasting disorder or emotional disturbance and those that are temporary and a natural reaction to a specific event in the child’s life. Children with problems that are temporary responses to stress would be excluded under the alternative definition. Those responding to outside events, such as divorce, death or natural disaster, may need mental health counseling but likely are not in need of special education and related services.

**Children from Birth to Age Six**

The federal definition makes no mention of very young children, ages 0-6, who may have mental/emotional disorders that qualify them for special services under the IDEA. The alternative definition recognizes this age group and makes reference to the need to assess very young children in appropriate settings, such as preschools or day care.

**Duration**

The federal definition requires that a child exhibit problems for “a long period of time” but does not indicate what this means. The alternative definition deletes this phrase as unnecessary and unhelpful. Instead, the alternative definition measures the significance of the child’s disability and its impact on the child’s ability to learn.

**Pre-Referral Services**

The federal definition makes no reference to providing services to children in the regular classroom before identifying them under the IDEA. The alternative definition requires pre-referral interventions, except in cases of obvious serious difficulties. It therefore encourages early preventive measures found through research to be effective.

**Diagnosis**

The federal definition references schizophrenia as a diagnosis included within this IDEA category. The alternative definition includes a broader but non-exhaustive list of disorders that can qualify a child because classroom programs for children with many mental/emotional disorders have much in common. The longer list of diagnoses would also enable schools to more readily recognize the significant group of children who have a co-morbidity and who qualify under more than one IDEA category. For example, many children with ADHD also have conduct disorders.

## **THE ALTERNATIVE DEFINITION AND IDENTIFICATION RATES**

States have flexibility to interpret the federal definition as long as an equivalent group of students is identified.<sup>52</sup> Prior studies have found that state definitions affect identification rates for students with emotional disturbance.<sup>53</sup> Generally, however, according to several studies, state definitions are consistent with the federal definition<sup>54</sup> and most states have not defined key terms left undefined in the federal rule.<sup>55</sup> This suggests that the impact of the problems with the federal definition is widespread.

In 2001-2002, the Bazelon Center for Mental Health Law collected and reviewed all 50 state definitions<sup>56</sup> of children with emotional disturbance under the IDEA to examine the degree to which the alternative definition recommended by national groups was being incorporated. This study examines the association between a state's making specified changes to the federal definition and identification rates for children with emotional disturbance in that state.

Each state definition was reviewed to identify differences between the state's rules and the federal definition with respect to 10 aspects of the alternative definition. Comparisons were then made between the number and type of these changes and the identification rates for children with emotional disturbance in the states, as published by the U.S. Department of Education.<sup>57</sup> The review looked at the most recent data available on identification and the most recent definitions in each state. Although states have generally not kept records of when their IDEA definitions were last changed, many definitions have been in place for years and, without compelling reasons for change, the tendency is to leave these definitions in place.

To facilitate comparisons, states were grouped into three categories: the 10 states with the lowest rate of identification for children with emotional disturbance, the 10 states with the highest rate of identification of such students and the remaining 30 states. Table 2 presents the states in the three categories and summarizes each state's modifications to the federal definition of emotional disturbance.

There were important differences in the average identification rates in each of these three groups of states. The 10 states with highest rates averaged 1.55 percent of school-age children identified as emotionally disturbed, while the 10 states with lowest identification rates averaged 0.37 percent. The national average was 0.94 percent.

This review identified states making each of the following changes:

- • deleting the federal definition's exclusion of children who are socially maladjusted;
- • including assessment of social, behavioral and other factors that can affect the child's performance;
- • referencing consideration of cultural issues;

## **A BAZELON CENTER ISSUE BRIEF**

- • referencing age-appropriate norms;
- • including language to indicate that the child's disability is not a temporary response to stressors;
- • referring to more than the sole diagnosis cited in the federal rule (schizophrenia) to include additional mental health diagnoses, as in the alternative definition, or dropping all reference to diagnosis;
- • defining the term "over a long period of time;"
- • referencing very young children, ages 0-6.

Results of this assessment confirm findings of earlier studies that the majority of states (60 percent) continue to use the federal definition without change, or with minor editorial changes unrelated to the criteria of the alternative definition. When the three groups of states are examined, a majority (6 of 10) in both the high-identification states and the low-identification states had made at least one of these changes. In contrast, only 10 states (33 percent) of the remaining 30 had made any of these changes. Accordingly, making at least one adjustment to the federal definition to address some aspects of the alternative definition does not, by itself, increase identification rates. On the other hand, when the total number of adjustments (101) made by the fifty states is considered, the 10 high-identification states represented a disproportionately large number of changes; high-identification states accounted for 37 percent of changes made by states nationwide, compared with 22 percent for the 10 low-identification states.

The changes made by the high-identification and low-identification states were further reviewed to determine whether certain changes were key. The changes most commonly made across all 50 states and the percentage of states in each of the three groups making these various changes appear in the table on the next page.

### **STATES MAKING CHANGES TO DEFINITION CONSISTENT WITH RECOMMENDATIONS IN THE ALTERNATIVE DEFINITION**

Changes to Language	Total Number of States Making the Change	Distribution of Change		
		High-ID States	Mid- ID States	Low-ID States
Inclusion of children under 6	4	75%	0	25%

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Dropping social maladjustment	10	50%	30%	20%
Deleting phrase "long period of time"	6	50%	33%	17%
Mentioning cultural issues	11	37%	45%	18%
Dropping reference to diagnoses	17	35%	47%	18%
Including social/behavioral factors	12	33%	42%	25%
Provision of other interventions first	12	33%	50%	17%
Assessed against norms	11	30%	45%	27%
Assessing in more than one setting	10	30%	40%	30%
Not a transient response to stress	8	38%	38%	25%

Although inclusion of children under age 6 was the change most unique to the high-identification states, only 3 of these states made this modification. Among the changes that occurred with significant frequency, elimination of the social maladjustment exclusion was notable. Fully half of the 10 high-identification states have eliminated this exclusion, and these states account for half of all states nationwide that have made this change. Moreover, the average identification rate among the five high-identification states that have eliminated the social maladjustment exclusion is 1.70, or 230 percent of the national average of 0.74.

The changes most often made by the 10 high-identification states were to: drop the references to diagnosis (six states), drop the exclusion of social maladjustment (five states), and (in four states each) mention social and behavioral factors that affect educational performance, the need to consider cultural factors and the need to have furnished less intensive services in the classroom prior to identification under the IDEA. While a greater number of high identification states dropped references to diagnosis than dropped the exclusion of social maladjustment, they represented only 35 percent of all states making this modification.

A second pattern that emerges from the data is that states making the largest number of changes were also more likely to be the states with the highest identification rates (see Table 2). Five (50 percent) of the states in the highest identification group<sup>58</sup> had made six or more changes, and three of them had made eight or nine of the 10 changes assessed. Only one (10 percent) of the low identification states and four (13 percent) of the 30 states in the middle group had made six changes or more. It may be that the correspondence

between high identification and changes in definitions reflects a deeper concern in these states for addressing the needs of children with mental or emotional disorders.

### **DISCUSSION**

These findings confirm earlier studies showing that most states follow the federal definition. This is especially true of states that are neither high- nor low-identifiers of children in the emotional disturbance category. Given that the changes examined were recommended by more than 30 national groups and endorsed as sound policy by the Council for Exceptional Children, it is somewhat surprising to find so few states adopting them.

However, this study also shows that states with the highest identification rates were more likely to make more, and more important, changes than the other states, and that these states are particularly likely to have dropped the exclusion of children with social maladjustment.

Accordingly, there appears to be an association between changes to the federal definition for determining eligibility under the IDEA to reflect the changes recommended by national groups and an improved rate of identification of children. However, even in the high-identification states, these rates are still very low when contrasted with prevalence data.

Changing the federal definition to incorporate parts of the alternative definition would appear helpful, but is clearly insufficient to raise identification rates to appropriate levels.

The types of changes made may have a far more significant effect than the number of changes made. Elimination of the social maladjustment clause appears to be most closely associated with higher identification rates. In addition, many of the highest-identification states have eliminated reference to any diagnosis, have referenced the need to consider social and behavioral factors and well as academic skills and to assess the child against cultural norms. They also encourage the use of other interventions in the regular classroom first and lead the way among the few that include children under six.

Finally, as discussed earlier, other factors also affect identification rates. Lack of resources and concern about costs that the school district might incur, lack of access to mental health services for identified children, stigma concerning the label of emotional disturbance and a desire to remove troublesome children perceived as not having a "real disability" may all contribute to overall low identification rates for children with mental and emotional disorders.

### **RECOMMENDATIONS FOR ACTION**

This study and the earlier research cited above indicate that changing the federal definition (either in law or regulation) to reflect the national groups' recommendations would likely improve identification of children with mental

and emotional disorders. However, such a change would need to be accompanied by other actions to remove barriers to identification if states are to ensure appropriate, early identification of children with significant mental and emotional disabilities who need the services and supports of the IDEA. For example, the federal government could foster greater collaboration between schools and public mental health systems, provide significantly more technical assistance for states and schools regarding childhood mental disorders and monitor more closely the rate of identification of children with emotional disturbance.

**The federal government should:**

- • adopt the alternative definition recommended by national groups, since the states have generally been slow to make such changes;
- • at a minimum, drop the social maladjustment exclusion in the federal definition and make the four other changes most commonly made by the higher-identification states (dropping reference to diagnosis, addressing social and behavioral issues, considering cultural issues and ensuring that pre-referral services have been furnished);
- • monitor identification rates for children with mental and emotional disorders and encourage states to address weaknesses in their identification procedures in order to raise these rates until they are more closely aligned with the 5 percent estimated prevalence rate of mental disorders causing extreme functional impairment;
- • monitor rates of identification for minority students more closely and work with states that are identifying a disproportionate number of some minorities or showing under-representation of certain cultural groups;
- • develop programs and materials to assist states in making more accurate assessments so as to correctly identify students with emotional disturbance in order to provide appropriate services and to encourage earlier identification, including identification of preschoolers and very young children; and
- • seek corrective action in states whose dropout, suspension and expulsion data reflect inappropriate identification and intervention policies and practices regarding students with emotional or behavioral disorders.

**States do not need to wait for federal action. States should:**

- • adopt the alternative definition recommended by national groups;
- • at a minimum, drop the social maladjustment exclusion in the federal definition;
- • assess their own programs to ensure that children of all cultural and ethnic groups are being appropriately identified by all schools; and
- • improve assessments of very young children.

In addition, state education agencies and local schools should collaborate with mental health agencies to design coordinated systems of care that use

resources from both systems to meet the comprehensive needs of children with mental and emotional disorders, including those identified as emotionally disturbed under the IDEA.

### **CONCLUSION**

Professional time and energy could be used more productively to create and provide appropriate special education and related services, rather than in conducting lengthy assessments that are failing to identify as many as four fifths of the children who should qualify as emotionally disturbed. Partnerships with mental health systems are needed to assist schools in providing an appropriate range of related mental health rehabilitation services to these students. Federal programs to encourage such collaborations exist and a number of states have developed impressive interagency collaborations. But more could be done.

Students with mental and emotional disorders exhibit behaviors that are hard to manage, especially if they do not receive the services they need. When they are misidentified as "socially maladjusted," such a result is all but assured. But if appropriate services were furnished earlier, based on appropriate identification, the outcomes could be very different.

Decades of underidentification, misidentification and delayed identification for special education have been self-defeating. The issues these children bring to school will not go away if they are ignored. The 5 to 11 percent of school-age children who have mental or emotional disorders must have fair access to special education and related services. The upcoming renewal of the IDEA presents another opportunity to address this long-neglected issue.

**NOTES**

1. This law was first enacted in 1975 as Public Law 94-142, and was later renamed the Individuals with Disabilities Act, 20 U.S.C. §1401(a).
2. Raver, C. Cybele, (2002). *Emotions Matter: Making the Case for the Role of Young Children's Emotional Development for Early School Readiness*. A Social Policy Report from the Society for Research in Child Development. Available at: [www.srcd.org/spr.html](http://www.srcd.org/spr.html)
3. Forness, Steven R., & Kavale, Kenneth A. (2001). Reflections on the future of prevention. *Preventing School Failure: Heldref Publications*, Winter 2001, 75-81.
4. President's Commission on Excellence in Special Education, (July 1, 2002). *A New Era: Revitalizing Special Education for Children and Their Families*. 22.
5. Weist, Mark, D., Axelrod Lowie, Jennifer, Flaherty, Lois and Pruitt, David, (2001). Collaboration among education, mental health and public health systems to promote youth mental health. *Psychiatric Services*. 52:10, 1348-1351.
6. Garfinkle, L. (1977, Spring). Youth with disabilities in the justice system: Integrating disability specific approaches. *Focal Point* 11 (1), 21-23; and SRI International (1991). *Youth with Disabilities: How Are they Doing? The First Comprehensive Report from the National Longitudinal Transition Study of Special Education Students*. CA:Menlo Park.
7. Leone, P.E., & Meisel, S. (1997). Improving education services for students in detention and confinement facilities. *Children's Legal Rights Journal*, 71 (1), 2-12.
8. Woodruff, Darren, Osher, David, Hoffman, Catherine, et al, *Promising Practices in Children's Mental Health, Volume III: the Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* (1998 Series). U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child, Adolescent and Family Branch, Rockville, MD.
9. President's Commission (2002).
10. *Mental Health, Schools and Families Working Together for All Children and Youth: Toward A Shared Agenda, A Concept Paper* (2002). National Association of State Mental Health Program Directors and the Policymaker Partnership for Implementing IDEA at the National association of State Directors of Special Education.
11. Weist et al. (2001).
12. When referring to identification under the IDEA, the federal term "emotional disturbance" will be used. When referring more generally to children significant need for mental health services, the term mental and emotional disorders will be used. This term emphasizes the existence of a diagnosable disorder using mental health criteria.
13. Coutinho, M., & Denny, K. (1996). National leadership for children and youth with serious emotional disturbance: Progress and prospects. *Journal of Child and Family Studies*, 5, 207-227.
14. Kauffman, J.M. (2001). *Characteristics of emotional and behavioral disorders* (7th ed.). Upper Saddle River, NJ: Prentice-Hall.
15. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
16. Various terms are used to describe these children in federal and state education regulations and in mental health rules. The federal law and definition refer to children who have "emotional disturbance." Some states refer to children with "behavioral disorders." For this report, the term mental and emotional disorders is used. This emphasizes the presence of a health disorder in these children, but is broad enough to include all such disorders.

17. U.S. Department of Education, Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (2001). Washington, D.C.: U.S. Department of Education.
18. Increasing it by only 0.3 percent, bringing the national average of children with emotional disturbance to no more than 1.04 percent.
19. Forness, Steven, & Knitzer, Jane, A New Proposed Definition and Terminology to Replace "Serious Emotional Disturbance" in Individuals with Disabilities Education Act, *School Psychology Review*, 21:1, 1992. Pp 12-20; and Kidder-Ashley, Pamela, Deni, James R., Azar, Kelly R. & Anderton, Jessica B., How 41 education agencies identify students with emotional problems. *Education*. 1999. 119:4, 598-609.
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21. Kidder-Ashley et al. (1999); Forness & Knitzer (1992); Forness & Kavale (2001); and Coutinho & Denny (1996).
22. Council for Children with Behavioral Disorders (1990). *Position Paper on Provision of Service to Children with Conduct Disorders*. *Behavioral Disorders*, 15, 180-189; Nelson, C.M., Rutherford, R.B., Center, D.B. & Walker, H.M. (1991). Do public schools have an obligation to serve troubled children and youth? *Exceptional Children*, 57, 406-415; Mattison, R.E., Morales, J., & Bauer, M.A. (1992). Distinguishing characteristics of elementary schoolboys recommended for ED placement. *Behavioral Disorders*, 17, 107-114; Forness et al. (1993); Maag, J.W., & Howell, K.W. (1992). Special education and the exclusion of youth with social maladjustments: A cultural organizational perspective. *Remedial and Special Education*, 13, 47-54; Forness, S.R. (1992). Broadening the cultural-organizational perspective in exclusion of youth with social maladjustment: First invited reaction to the Maag and Howell paper. *Remedial and Special Education*, 13, 55-59; Nelson, C.M., & Rutherford, R.B. (1990). Troubled youth in the public schools: Emotionally disturbed or socially maladjusted? In P.E. Leone (Ed.), *Understanding Troubled and Troubling Youth: Multidisciplinary Perspectives*, 38-60. Newbury Park, CA: Sage; and Nelson, C. Michael, (1992) Searching for meaning in the behavior of antisocial pupils, public school educators and lawmakers. *School Psychology Review*, 21:1, 35-39.
23. Cohen, M.K. (1994). *Children on the Boundary: The Challenge Posed by Children with Conduct Disorders*. Alexandria, VA: National Association of State Directors of Special Education; Forness & Knitzer (1992); pp 12-20; Maag & Howell (1992); and Nelson (1992).
24. Kauffman, J.M. (1999). How we prevent the prevention of emotional and behavioral disorders. *Exceptional Children*, 65, 448-468.; and Forness & Kavale (2001).
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27. Forness & Kavale (2001).
28. Fewer than half of children with emotional disturbance in special education are mainstreamed following identification, (Forness & Knitzer, 1992) and two thirds of all special education students in the most restrictive settings are those with emotional disturbance. Skiba, R., & Grizzle, K., (1991). The social maladjustment exclusion: Issues of definition and assessment. *School Psychology Review*, 20, 577-595; and Forness, Steven R. (1992). Legalism versus professionalism in diagnosing SED in the public schools. *School Psychology Review*, 21:1, 29-34.)
29. Forness & Kavale (2001) and Forness, S. R., & Kavale, K.A. (2000). Emotional or behavioral disorders. Background and current status of the EBD terminology and definition.

## **A BAZELON CENTER ISSUE BRIEF**

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43. Forness & Knitzer (1992) and Forness (1992).

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## **A BAZELON CENTER ISSUE BRIEF**

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57. U.S. Department of Education, Twenty-Third Annual Report to Congress (2001).
58. Florida, Iowa, Minnesota, Georgia and Wisconsin.

## A BAZELON CENTER ISSUE BRIEF

Table 1: Number of Children Ages 6-21 Served Under Part B, IDEA As Emotionally Disturbed (2001) Compared with Estimates of Number of Children with Mental Disorders and Functional Impairments: By State

State	Children Identified as Emotionally Disturbed Under IDEA	Children with Severe Functional Impairment	Children with Serious Functional Impairment	State	Children Identified as Emotionally Disturbed Under IDEA	Children with Severe Functional Impairment	Children with Serious Functional Impairment
AL	5,339	38,337	60,244	MT	1,001	8,878	13,952
AK	803	4,548	8,186	NE	2,819	11,552	20,793
AR	5,833	37,941	59,622	NV	1,642	9,335	16,803
AZ	449	23,640	37,149	NH	2,387	7,385	13,293
CA	21,182	277,827	436,585	NJ	13,544	46,634	83,940
CO	8,625	24,597	44,274	NM	3,258	17,586	27,635
CT	7,420	22,708	37,847	NY	44,679	149,900	235,558
DE	636	4,270	7,686	NC	10,278	52,745	87,909
DC	1,079	3,386	5,320	ND	969	4,572	8,230
FL	36,585	113,659	178,607	OH	14,449	87,073	145,122
GA	23,638	56,530	94,216	OK	3,835	32,025	50,325
HI	3,147	7,195	12,951	OR	4,467	24,693	41,154
ID	753	11,030	18,383	PA	18,845	87,764	146,273
IL	30,652	106,203	166,890	RI	2,395	5,759	10,366
IN	11,369	37,932	68,277	SC	6,049	32,961	51,796
IA	9,665	23,135	38,558	SD	618	6,531	10,886
KS	4,222	17,736	31,925	TN	3,541	46,100	72,443
KY	5,741	30,262	50,437	TX	36,267	183,656	288,602
LA	5,479	44,741	70,307	UT	3,806	17,454	31,418
ME	3,899	8,022	14,439	VT	2,062	4,590	7,650
MD	8,679	36,493	60,821	VA	13,087	39,518	71,132
MA	13,042	40,806	68,010	WA	4,950	42,874	71,457
MI	18,421	76,527	127,545	WV	2,166	16,197	25,453
MN	17,717	32,195	57,950	WI	16,162	35,300	63,540
MS	575	27,489	43,196	WY	931	4,506	7,511
MO	9,427	35,472	63,850				

Sources: U.S. Department of Education, Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (2001). Washington, D.C.: U.S. Department of Education; and Friedman, Robert, Kotz-Leavy, Judith, Manderscheid, Ronald & Sondheimer, Diane, Prevalence of Serious Emotional Disturbance: An Update (1998) in *Mental Health U.S. 1998*, Center for Mental Health Services, Rockville, MD: Supt of Documents, U.S. Government Printing Office, 1998.

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Table 2: States' Identification Rates and Modifications to the Federal Definition of Emotional Disturbance

	State	ID Rate*	UNDER 6	SOCIAL MAL	LONG TIME	CULTURAL	DIAGNOSIS	SOC/BEHAV	INTERVENT	NORMS	SETTINGS	TRANSIENT
HIGH IDENTIFICATION STATES	MN	1.92	X	X		X	X	X	X	X	X	X
	VT	1.92					X					
	IA	1.84	X	X	X	X	X	X	X	X		
	ME	1.77										
	GA	1.69	X	X	X	X	X					X
	WI	1.61		X		X	X	X	X	X	X	X
	HI	1.56										
	FL	1.43		X	X		X	X	X		X	
	NY	1.40										
	IL	1.37										
MID IDENTIFICATION STATES	RI	1.28										
	CT	1.20										
	MA	1.20					X					
	CO	1.14		X	X	X	X	X	X	X	X	X
	VA	1.10										
	IN	1.05		X			X					
	NH	1.03										
	MI	0.99				X						
	WY	0.97										
	MO	0.94										
	MD	0.92										
	TX	0.91										
	NJ	0.91		X			X					
	NM	0.91										
	SC	0.90										
MID IDENTIFICATION STATES	PA	0.88										
	NE	0.88										
	KY	0.85				X	X	X	X	X	X	X
	KS	0.83										
	ND	0.82										
	UT	0.80										
	NC	0.77			X		X	X	X	X		
	OR	0.76										
	WV	0.73							X			
	AL	0.71				X	X	X	X	X	X	X
LOW IDENTIFICATION STATES	OH	0.70										
	AZ	0.64										
	LA	0.64				X	X	X	X	X	X	X
	OK	0.61										
	MT	0.60										
	AK	0.56										
	DE	0.50		X		X	X	X		X		
	NV	0.49	X		X		X	X	X	X	X	
	WA	0.46										
	SD	0.43							X			X
LOW IDENTIFICATION STATES	TN	0.37										
	CA	0.33		X			X				X	
	ID	0.30									X	X
	MS	0.11				X		X		X		
	AR	0.10										

**KEY TO MODIFICATIONS:**

UNDER 6 - Inclusion of children under 6  
 SOCIAL MAL- Dropping social maladjustment  
 LONG TIME- Deleting phrase "long period of time"  
 CULTURAL- Mentioning cultural issues  
 DIAGNOSIS- Dropping references to diagnoses

SOC/BEHAV- Including social/behavioral factors  
 INTERVENT- Provision of other interventions first  
 NORMS- Assessed against norms  
 SETTINGS- Assessing in child more than one setting  
 TRANSIENT- Not a transient response to stress

\* Source: U.S. Department of Education, Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (2001). Washington DC: U.S. Department of Education. ID Rates represent the percentage of children, ages 6-17 with emotional disturbance served under IDEA, Part B, during 1999-2000 school year.

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